PRTF APPLICATION AND ADMISSION ASSESSMENT FORM

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YOUTH INFORMATION

Child's Full Legal Name: _____ DOB: _____ Age: _____

Child's SSN: _____ JETS/TIPS #_____ Is child emancipated, married or had a child? ☐ Yes ☐ No

Bayou Health Plan: ☐Aetna ☐Amerigroup ☐Amerihealth Caritas ☐Louisiana Healthcare Connections ☐United Health Care

Medicaid #: _____ BHP Member #: _____

Any other Insurance available? _____

Allergies: _____

Sex: ☐Male ☐Female Height: _____ Weight: _____ Ethnicity/Race: _____ Eye Color: _____ Hair Color: _____

Child's Living Arrangement: ☐ Parents ☐ Group Home ☐ Foster Home ☐ Detention ☐ Other: _____

Child's Living Arrangement Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Referring Party: _____ Phone #: _____

DCFS/OJJ/DHH/PRI Name: _____ Email: _____

Work#: _____ Fax#: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Name the Adult(s) that has Custody of the Child *(please provide custody order if necessary)*:

Father: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Mother: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Other 1: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Other 2: _____ Rights? Yes / No Hm# _____ Cell# _____ SSN: _____

Is child a previous resident of LMCH? ☐ Yes ☐ No If "Yes" what dates: _____

CURRENT BEHAVIORS

Why is admission into a PRTF required at this time? _____

_____

RISK ASSESSMENT

Is there risk or history of the child **attempting suicide**? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

_____

Is there risk or history of the child **harming self/others**? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

_____

Is there risk or history of the child **harming animals**? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

_____

Is there risk or history of the child starting **fires**? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

_____

Is there risk or history of the child **acting out sexually** with others? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.:

_____

_____

Is there risk or history of the child **running away**? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

Are there other **needs, activities or behaviors** that put this child at special risk? ☐ Yes ☐ No. If "yes", explain with behaviors, dates of events, etc.: _____

_____

SUBSTANCE USE

Does this child have a history of substance use? ☐ Yes ☐ No. If "yes", describe in detail (what substance, frequency of use, amount, duration, last use, urinary drug screen results): _____

_____

_____

_____

COORDINATED SYTEM OF CARE INVOLVEMENT

Has the child or family received case management or support services from CSOC, WAA, FSO, CFT, Magellan:

A Wrap Around Agency? ☐ Yes ☐ No If, "yes", which WAA? _____

If, "yes", the WAA worker's name: _____

A Family Support Organization? ☐ Yes ☐ No If, "yes", which FSO? _____

If, "yes", the FSO worker's name: _____

A Magellan RCM Case Manager? ☐ Yes ☐ No If, "yes", name of Case Manager: _____

A Child and Family Team? ☐ Yes ☐ No If, "yes", names of CFT participants: _____

_____

_____

TARGETED TREATMENT GOALS

What are the goals for treatment which cannot be met in a less intensive level of care? _____

_____

_____

_____

_____

PREVIOUS TREATMENT

Has child received treatment from an Outpatient Therapist? ☐ Yes ☐ No

Name/Credentials: _____ Phone: _____

Start Date: _____ Last Appt: _____ Freq: Weekly Bi-Monthly Monthly Mode: Indiv Family Group

Provide History of Child's Previous Hospitalizations and Out-of-Home Placements:

Name and Type of Facility	Admit Date	Discharge Date	Reason for Placement

Current Psychiatric Diagnosis

Date of Diagnosis: _____ Assessment Performed by: _____

AXIS I: _____

_____

AXIS II: _____

_____

AXIS III: _____

_____

AXIS IV: _____

_____

AXIS V: _____

_____

GAF: Current _____ Highest in Last Year _____

FAMILY INFORMATION

CURRENT FEMALE CARETAKER (MOTHER, AUNT, GRANDMOTHER, ADOPTIVE MOTHER, ETC.)

Full Name: _____ Date of Birth: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Years of School Completed: _____ Employer: _____Job: _____

CURRENT MALE CARETAKER (FATHER, UNCLE, GRANDFATHER, ADOPTIVE FATHER, ETC.)

Full Name: _____ Date of Birth: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Years of School Completed: _____ Employer: _____Job: _____

SIBLINGS

Sibling's Name	Sex	Age or DOB	Lives with

Have Parental Rights been Terminated for Biological Parents: ☐No ☐Yes _____

Anyone the child is *NOT* permitted to have contact? (legal documentation is required, ie. Court Order)

_____

_____

EDUCATIONAL INFORMATION

Last School Attended: _____ Grade: _____

School Address: _____

City: _____ Parish: _____ State: _____ Zip: _____

List school behavior strengths: _____

_____

List school behavior weaknesses: _____

_____

MEDICAL INFORMATION

Child's Primary Care Physician: _____ Phone: _____

Street: _____ City: _____ State: _____ Fax: _____

Last time youth had a visit with PCP: _____

Please describe child's current physical health / medical problems:

Medical problem, diagnosis, doctor	How long?	Describe current treatment (medication, etc.)

Please List ALL Current Medications:

Name of Medication and Dosage, Route, Frequency	Prescribed by:	Prescribed as Treatment for:

Is child compliant with current prescribed medications? ☐ Yes ☐ No

Are child's Immunizations Current? (Check one): ☐ Yes ☐ No *You MUST provide a COPY OF CHILD'S IMMUNIZATION RECORD.*

HISTORY OF ABUSE, NEGLECT AND CRIME VICTIMIZATION

Please describe the child's history of abuse, neglect and crime victimization:

Physical Abuse: _____

Sexual Abuse: _____

Mental/Emotional Abuse: _____

Neglect: _____

Exposure to Domestic Violence: _____

Exposure to Pornography: _____

Exposure to Adult Sexual Behavior: _____

Sexual Maladaptive Behaviors: _____

Victim of a Crime: _____

FUNCTIONAL STRENGTHS

For each area of life below, please indicate the child's strengths.

Social: _____

Family: _____

School: _____

Religious: _____

ADLS: _____

Other areas of life: _____

SUPPORT SYSTEMS

In each area below, list the individuals who are actively supportive of the child and/or family.

Family: _____

Social: _____

School: _____

Religious: _____

Treatment/Therapeutic: _____

Please describe the child's religious preference:

_____

STATEMENT OF APPLICATION FOR ADMISSION

Name of Person Completing this Application: _____

Relationship to Child: _____ Date: _____

I (we), the undersigned Parent(s) or Legal Guardian(s), do hereby apply to Louisiana United Methodist Children and Family Services, Inc. for Psychiatric Residential Treatment Facility (PRTF) services for the child named above for whom I (we) hold legal custody and/or placement authority. I (we) certify the information provided in this PRTF Application and Admission Assessment Form and the attached documents is true and accurate to the best of my (our) knowledge. I (we) agree to share additional information related to this application as it becomes available and/or is requested by Louisiana United Methodist Children and Family Services. I (we) also agree to fully cooperate with Louisiana United Methodist Children and Family Services and to actively support the child's plan of care to which we mutually agree.

Does any other adult have legal rights to this child? ☐ Yes ☐No

If, "Yes", please provide name and explain: _____

_____

Signatures of Parent(s) or Legal Guardians(s) Requesting Child's Admission

_____ _____

Parent Signature Date

_____ _____

Printed Name Relationship to Child

_____ _____

Parent Signature Date

_____ _____

Printed Name Relationship to Child

_____ _____

Legal Guardian Signature Date

_____ _____

Printed Name Relationship to Child